STATE OF MAINE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF LICENSING AND REGULATORY SERVICES
-

Behavioral Health Program

Alcohol and Drug Treatment Program Application

SECTION 1: Facility Information			
Facility/Agency Name:			
Physical Address:			
City:	State:	Zip:	County:
Mailing Address:			
City:	State:	Zip:	County:
Telephone No.: ( )		Fax No.: ( )	
Email Address:		State Tax ID or Employer ID No.:	

SECTION 2: Fees	
APPLICATION FOR ALCOHOL AND DRUG TREATMENT PROGRAM	
License Type (Select all that apply): ☐ New License (fee $50) ☐ Renewal License (fee $50) **Total Fee Enclosed for application ……**	$ 50.00
☐ Add a Service & Renewal (fee $50.00 x # of services: _____) ☐ Detox, Medical Model ☐ Detox, Social Setting ☐ Shelter ☐ Extended Shelter ☐ Assisted, Medical Model ☐ Extended Care Residential Rehab ☐ Halfway House ☐ Outpatient Care ☐ Non-Residential Rehab ☐ Methadone Treatment ☐ DEEP-Driver Ed. Evaluation Program **Total Fee Enclosed for adding a service(s) ……**	$ _____
☐ Add a Site (fee $25 x # of new sites: _____) **Total Fee Enclosed for adding a site(s) ……**	$ _____
Make check or money order payable to "Treasurer, State of Maine". Do not send Cash. **Credit Cards are not accepted at this time. Total Check/Money Order Enclosed: =**	**$** _____

For questions regarding this program and/or application, please contact the following:
Department of Health and Human Services
Licensing and Regulatory Services
Behavioral Health Program
41 Anthony Ave; 11 State House Station
Augusta, ME 04333-0011

Tel: (207) 287-4399 Fax: (207) 287-2671 Toll Free: 1-800-791-4080 TTY users call Maine relay 711
Email: info.dhhs@maine.gov

Office Use Only:
Check# _____ *MO #* _____ *Amount $*_____ *Initials:* _____ *License#* _____

SECTION 3: Facility Contact Information			
Name and Title of Primary Contact Person:			
Telephone No.: ( )	Email Address:		
Name and Title of Administrator/Operator:			
Telephone No.: ( )	Email Address:		
Name and Title of Executive Director:			
Telephone No.: ( )	Email Address:		
Corporation Name (if applicable):			
Mailing Address:			
City:	State:	Zip:	County:
Telephone No.: ( )	Fax No.: ( )		

SECTION 4: Facility Information

Accreditation:

Is the facility accredited?

- ☐ No
- ☐ Yes, Please indicate which accrediting agency: _____
  How many years has the facility held this accreditation? _____

Type of facility:

- ☐ Individual Proprietorship
- ☐ Non-Profit Corporation
- ☐ Tribal Government
- ☐ Church
- ☐ Partnership
- ☐ Parent Co-Op
- ☐ Other (describe): _____

Services:

- ☐ License (Residential Treatment Program)
- ☐ Certificate of Approval (Non-Residential Treatment Program)

Catchment Area: (Geographic Area Served) _____

Residential License: (Check each component to be reviewed)

- ☐ Detox, Medical Model Number of Beds: _____
- ☐ Detox, Social Setting Number of Beds: _____
- ☐ Shelter Number of Beds: _____
- ☐ Extended Shelter Number of Beds: _____
- ☐ Assisted, Medical Model Number of Beds: _____
- ☐ Extended Care Residential Rehab Number of Beds: _____
- ☐ Halfway House Number of Beds: _____

Waiver Request: If you are requesting a new waiver/exception or an extension, please describe your request:

_____
_____
_____
_____

SECTION 5: Staff Roster
Complete the following information. Use additional paper if necessary.

Full Name:	Title:	Date of Birth:
Education/Degree:	License/Certification:	
Supervisor:	Supervisor’s Title:	

Full Name:	Title:	Date of Birth:
Education/Degree:	License/Certification:	
Supervisor:	Supervisor’s Title:	

Full Name:	Title:	Date of Birth:
Education/Degree:	License/Certification:	
Supervisor:	Supervisor’s Title:	

Full Name:	Title:	Date of Birth:
Education/Degree:	License/Certification:	
Supervisor:	Supervisor’s Title:	

Full Name:	Title:	Date of Birth:
Education/Degree:	License/Certification:	
Supervisor:	Supervisor’s Title:	

Full Name:	Title:	Date of Birth:
Education/Degree:	License/Certification:	
Supervisor:	Supervisor’s Title:	

Full Name:	Title:	Date of Birth:
Education/Degree:	License/Certification:	
Supervisor:	Supervisor’s Title:	

Full Name:	Title:	Date of Birth:
Education/Degree:	License/Certification:	
Supervisor:	Supervisor’s Title:	

Full Name:	Title:	Date of Birth:
Education/Degree:	License/Certification:	
Supervisor:	Supervisor’s Title:	

SECTION 6: Services being applied for
Complete the following information. Use additional paper if necessary.

Module Type:		Service:
Age Range:	Gender:	Number of Clients:
Address:		

Module Type:		Service:
Age Range:	Gender:	Number of Clients:
Address:		

Module Type:		Service:
Age Range:	Gender:	Number of Clients:
Address:		

Module Type:		Service:
Age Range:	Gender:	Number of Clients:
Address:		

Module Type:		Service:
Age Range:	Gender:	Number of Clients:
Address:		

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Age Range:	Gender:	Number of Clients:
Address:		

Module Type:		Service:
Age Range:	Gender:	Number of Clients:
Address:		

Module Type:		Service:
Age Range:	Gender:	Number of Clients:
Address:		

Module Type:		Service:
Age Range:	Gender:	Number of Clients:
Address:		

SECTION 7: Submission

Remember to submit the following documents with your completed application:

- A check or money order made payable to "Treasurer, State of Maine"
- Fire Inspection Form (Required for ALL new sites) - Appendix A
- Organizational Chart
- List of Governing Body Members/Offices held/Addresses
- Staff roster
- Program descriptions
- Program admission criteria for each program
- Any new or changed policies
- Submit current water test for each site not on public water

In addition, first time applicants must also submit:

- Articles of Incorporation
- Assurance of Compliance (ADA/EEO)
- Complete Policy and Procedures Manual
- Sample client file

SECTION 8: Declaration

I/We have received and read the rules for the licensing process. I/We understand that this application authorizes representatives of the Department of Health and Human Services and the State Fire Marshal's Office (if applicable) to make such visits and inspections as may be necessary to ensure that the facility is in compliance with the laws pertaining to the operation of such facilities.

I/We also understand that the signing of this application effectively serves as a release of information and gives permission to the Department of Health and Human Services to obtain any criminal or protective records information which may be on file in any Country, State or Federal Office. I/We understand any falsification of statement may be grounds for denial.

I/We further certify that all information contained in this application (including Appendix) is complete and accurate.

_____	_____	_____
Print name of Applicant/Operator/Administrator	**Signature of Applicant/Operator/Administrator**	**Date**
_____	_____	_____
Print name of 2nd Applicant (If Applicable)	**Signature of 2nd Applicant (If Applicable)**	**Date**
_____	_____	_____
Print name of Board President (If Applicable)	**Signature of Board President (If Applicable)**	**Date**

Fire Inspection Request and Address Change Form
Type of License: ALCOHOL AND SUBSTANCE ABUSE

Services cannot be provided at any location until Licensing and the Fire Marshal's Office have approved the site.

FORM MUST BE COMPLETED BY:

1. New Applicants: Complete one (1) form for each site from which you plan to deliver services and return with your application. (Complete a separate form for each site).
2. All Applicants: Complete and submit form when you are adding a new site, changing your address, or closing a site. (Retain a copy of this form for your records).

MAIN SITE:
Agency Name: _____ Date: _____
Operator/Executive Director: _____ Telephone: _____
Address: Contact Person (if different):
_____ _____
_____
_____ Phone: _____
(City, State, Zip)

Description of Services: _____
_____

Age Range of Clients Served: _____ Maximum Capacity: _____

Residential: _____ Non-Residential: _____

Directions to Facility: (Be specific with known landmarks.) _____
_____
_____
_____

COMPLETE ONLY IF CHANGE:
Services cannot be provided at any location until Licensing and the Fire Marshal's Office have approved the site.

New Program/Agency In Process of Licensure: ☐ No ☐ Yes, date of submitted application: _____

☐ Closing Existing Site Current Address: _____
_____

☐ Moving Office Site within Same Building _____

☐ Adding New Site New Address: _____
_____

Date of Expected Move: _____
Contact Person: _____ Telephone: _____

Water Source: ☐ Municipal ☐ Well ☐ Other: _____

Directions to Facility: (Be specific with known landmarks.) _____
_____
_____